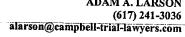
CAMPBELL CAMPBELL EDWARDS & CONROY PROFESSIONAL CORPORATION

ONE CONSTITUTION PLAZA THIRD FLOOR

BOSTON, MA 02129 TEL: (617) 241 3000 FAX: (617) 241 5115

ADAM A. LARSON (617) 241-3036



September 29, 2006

Joseph M. Mahaney, Esq. Goguen, McLaughlin, Richards & Mahaney, P.C. The Harrier Beecher Stowe House 2 Pleasant Street South Natick, MA 01760

> Steven McDermott et al. vs. FedEx Ground Package System, Inc. et al. Re: U.S.D.C. District of Massachusetts C.A. No.: 1:04-CV-12253-JLA

Dear Joe:

This will confirm that we have provided you on August 9, 2006 with a HIPAA release for Dr. Krishna Nirmel's records for your client's signature. As of today, we have not received the signed HIPAA release.

Also, enclosed please find HIPAA releases for the following providers, which have refused to release plaintiff's medical records unless provided with a signed HIPAA release:

- 1. Herbert Cares, M.D.;
- 2. Surgical Neurology;
- Nancy Altman; and 3.
- 4. Wayside Metrowest Counseling Center.

Please forward the signed releases to my attention at your earliest convenience as it takes time to obtain the records.

If we do not receive the signed releases within one week, we will file a motion for a Court Order to obtain one.

Thank you.

Very truly yours, Adam Lauson

Adam A. Larson

/ir Enc.

cc:

Michael Brown, Esq.





Ι.	Talishna 14. 14h mei, 141.D.		to us	to use or disclose the				
	(Nai							
	following protected information	from the records of the nationalist	ed below. Tunderstan	d that information				
	used or disclosed pursuant to this	s authorization could be subject to	redical cours by the was	u mat miormanoj				
	may not be subject to federal or s	state law protecting its confidentia	lity	pient and, it so,				
		protecting its confidentia	inty.					
2.	Patient Name: Steven N	McDermott						
	Date of Birth:	Tebel mott						
	Social Security #:							
		1						
	270 Madellanie Street							
	Bellingh	am, MA 02019						
2	Information () 11 1	_						
3.	Information to be disclosed to:	Campbell Campbell Edwards & (Conroy, P.C.					
		Name	-					
	1 Constitution Plaza	Boston	MA	02129				
	Address	City	State	Zip				
		•	No.	ZAP				
4.	Disclose the following information	for treatment dates: 1995	to <u>Present</u>					
	(circle appropriate categories)	2220	rosent					
	,							
	X Complete Records	X X-Ray						
	X Abstract	X Laboratory						
	X Face Sheet							
	X Discharge Summary	X Pathology						
	Y Uistory and Dharial	X Physical Therapy						
	X History and Physical X Emergency Reports							
	$\frac{\mathbf{X}}{\mathbf{Y}}$ Consult $\frac{\mathbf{X}}{\mathbf{Y}}$ Psychotherapy Records							
	\underline{X} Outpatient Reports \underline{X} Other specified *All radiology films							
_								
5.	The above information is disclosed for the following purposes: (circle appropriate categories)							
				,				
	Medical Care <u>Legal</u> Insuranc	ce Personal At request of th	e individual Other					
_			•					
6.	I understand that I may revoke au	thorization at any time by request	ting such of the above re	faranced beenited				
	I understand that I may revoke authorization at any time by requesting such of the above referenced hospital or physician practice in writing unless action has already been taken in reliance upon it, or during a							
	contestability period under applica	contestability period under applicable law.						
	•							
7.	This authorization expires upon ter	mination of the litigation						
8.	I further authorize you to accept either an original or a photostatic copy of this authorization, each having the							
	same full force and effect as if it we	are itself the existing!	opy of this authorization	i, each having the				
	The second secon	re usen the original.						
9.		40						
•	Signature of Patient or Legal Rep	10						
	Signature of Fattent of Legal Rep	resentative Date						
	Stavan MaDamas #							
	Steven McDermott	11						
	Printed name of patient	Relationship to	o patient or					
	or patient's representative	authority to ac						

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH **INFORMATION**

1.

1.	I hereby authorize	Herbert Cares, I	M.D	to no	se or disclose the	
		(Name of hospita	l/physician)			
	asea or aisciosea hars	formation from the reco want to this authorization federal or state law prot	rds of the patient list	redisclosure by the rec	d that information ipient and, if so,	
2.	Patient Name: Date of Birth: Social Security #: Address:	Steven McDermott 175 Mechanic Street Rollingham, MA 0202	10			
3.	Bellingham, MA 02019 Information to be disclosed to: <u>Campbell Campbell Edwards & Conroy, P.C.</u>					
	1 Constitution Plaza	Name	Dogton	3.5.		
	Address		Boston City	MA State	02129	
			•	State	Zip	
4.	Disclose the following i (circle appropriate cate	nformation for treatmen egories)	nt dates: <u>1995</u> t	o <u>Present</u>		
	X Complete R	decords X X	-Dow			
	X Abstract		-Nay aboratory			
	\overline{X} Face Sheet		athology			
	X Discharge S					
	 X Discharge Summary X Physical Therapy X History and Physical X Emergency Reports 					
	X Consult X Psychotherapy Records					
	$\frac{\underline{\underline{\underline{X}}}}{\underline{\underline{X}}}$ Outpatient 1	Reports X O	ther specified *All ra	s udiology Glus		
		-				
5.	The above information is disclosed for the following purposes: (circle appropriate categories)					
	Medical Care <u>Legal</u>	Insurance Person:	1			
5.	I understand that I may or physician practice in contestability period un	writing unless action ha	t any time by request is already been taken	ing such of the above re in reliance upon it, or o	eferenced hospital during a	
7.	This authorization expires upon <u>termination of the litigation</u> .					
8.	I further authorize you same full force and effect	to accept either an origi ct as if it were itself the o	nal or a photostatic co original.	opy of this authorization	n, each having the	
9.			10			
	Signature of Patient or	Legal Representative	Date			
	Steven McDermott		11			
	Printed name of patient		Relationship to	patient or		
	or patient's representat	tive	authority to ac	t for patient		

IMPORTANT: THIS AUTHORIZATION SHALL BE DEEMED INVALID UNLESS ALL NUMBERED ENTRIES ARE COMPLETED

	I hereby authorize			to	use or disclose the		
	(Name of hospital/ph	ysician)				
	following protected informati	on from the records	of the patient list	ed below. Tunderstan	d that information		
	used or disclosed pursuant to	this authorization co	ould be subject to	radisclosure by the rec	iniont and it so		
	may not be subject to federal	or state law protecti	na its confidential	it	ipient and, ii so,		
	y be subject to leact at	or state law protects	ng its confidential	ity.			
2.	Patient Name: Steve	en McDermott					
	Date of Birth:						
	Social Security #:						
	•	Mank and Co					
	Belli	ngham, MA 02019					
3.	Information to be disclared to						
٥.	Information to be disclosed to		<u>bell Edwards & C</u>	Conroy, P.C.			
	1.0	Name					
	1 Constitution Plaza		Boston	MA_	02129		
	Address		City	State	Zip		
	D'-1 - 4 - 6 11 - 4 - 6						
4.	Disclose the following informa		ates: <u>1995</u> t	o <u>Present</u>			
	(circle appropriate categories)						
	X Complete Records	<u>X</u> X-Ra					
	$\underline{\mathbf{X}}$ Abstract	X Labo	ratory				
	X Face Sheet	X Patho	ology				
	X Discharge Summar		cal Therapy				
	X History and Physic		gency Reports				
	X Consult		otherapy Record	s			
	X Outpatient Reports	$\overline{\mathbf{X}}$ Other	r specified *All ra	adiology films			
	-	-	•				
5.	The above information is disclosed for the following purposes: (circle appropriate categories)						
			• • •	II I amic amagain	-,		
	Medical Care <u>Legal</u> Insur	ance Personal	At request of th	e individual Other			
6.	I understand that I may revoke	e authorization at ar	y time by request	ing such of the above r	eferenced hospital		
	I understand that I may revoke authorization at any time by requesting such of the above referenced hospital or physician practice in writing unless action has already been taken in reliance upon it, or during a						
	contestability period under ap	olicable law.		an remained upon it, or	during a		
7.	This authorization expires upon	termination of the	litigation.				
	• •						
8.	I further authorize you to accept either an original or a photostatic copy of this authorization, each having th						
	same full force and effect as if it were itself the original.						
	11 11 11 11 11 11 11 11 11 11 11 11 11	o were resert the orig	11141.				
9.			10				
-	Signature of Patient or Legal 1	Panrasantativa	Date				
	Signature of Lutterit of Legal	cpi esentative	Date		•		
	Steven McDermott		11.				
	Printed name of patient		Relationship to	- madiand			
	or patient's representative						
	or harrour a rehrescurative		authority to ac	et for patient			

1.	I hereby authorize	Nancy Altman		to	use or disclose the	
	used or disclosed purs	(Name of hospital formation from the recon suant to this authorization federal or state law prote	rds of the patient listent could be subject to	d below. I understand	that information	
2.	Patient Name: Date of Birth: Social Security #: Address:	Steven McDermott 175 Mechanic Street Bellingham, MA 0201	9			
3.	Information to be disclosed to: Campbell Campbell Edwards & Conroy, P.C. Name					
	1 Constitution Plaza	. I will	Boston	MA	02129	
	Address		City	State	Zip	
4.	Disclose the following information for treatment dates: 1995 to Present (circle appropriate categories)					
	 X Complete I X Abstract X Face Sheet X Discharge X History and X Consult X Outpatient 	X La X Pa Summary X Pt d Physical X Es X Ps	Ray aboratory athology nysical Therapy nergency Reports nychotherapy Records ther specified *All ra			
5.	The above information is disclosed for the following purposes: (circle appropriate categories)					
6.	Medical Care <u>Legal</u> I understand that I ma or physician practice i contestability period u	y revoke authorization a n writing unless action ha	t any time by request	ing such of the above re	ferenced hospital luring a	
7.	This authorization expi	res upon <u>termination of t</u>	he litigation.			
8.	I further authorize you to accept either an original or a photostatic copy of this authorization, each having the same full force and effect as if it were itself the original.					
9.			10.			
	Signature of Patient o	r Legal Representative	Date			
	Steven McDermott		11.			
	Printed name of patier or patient's represent		Relationship to authority to ac			

IMPORTANT: THIS AUTHORIZATION SHALL BE DEEMED <u>INVALID</u> UNLESS ALL NUMBERED ENTRIES ARE COMPLETED

1.	1 hereby authorize <u>Wayside</u>	Metrowest Counseling Center	to use	or disclose the			
	(Name of	f hospital/physician)					
	following protected information from	the records of the patient listed be	low. I understan	d that information			
	following protected information from the records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so,						
	may not be subject to federal or state	law protecting its confidentiality	scrobule by the rec.	ipient anu, ii so,			
	and a second	aw protecting its confidentiality.					
2.	Patient Name: Steven McDe	ermott					
	Date of Birth:						
	Social Security #:						
	Address: 175 Mechani	c Street					
	Bellingham, I	MA 02019					
	Ç ,						
3.	Information to be disclosed to: Cam	npbell Campbell Edwards & Conro	ov. P.C.				
	Nam		7,110				
	1 Constitution Plaza	Boston	MA	02129			
	Address	City	State	Zip			
		·		F			
4.	Disclose the following information for	treatment dates: 1995 to Pro	<u>esent</u>				
	(circle appropriate categories)						
	X Complete Records	X X-Ray					
	X Abstract	\overline{X} Laboratory					
	X Face Sheet	$\frac{\overline{\mathbf{X}}}{\mathbf{X}}$ Pathology					
	X Discharge Summary	$\frac{\overline{\mathbf{X}}}{\mathbf{X}}$ Physical Therapy					
	$\overline{\underline{\mathbf{X}}}$ History and Physical	X Emergency Reports					
	$\overline{\underline{\mathbf{X}}}$ Consult	X Psychotherapy Records					
	X Outpatient Reports X Other specified *All radiology films						
5.	The above information is disclosed for the following purposes: (circle appropriate categories)						
	Medical Care <u>Legal</u> Insurance	Personal At request of the ind	lividual Other				
_	• •		_				
6.	I understand that I may revoke author	ization at any time by requesting s	uch of the above re	eferenced hospital			
	or physician practice in writing unless action has already been taken in reliance upon it, or during a						
	contestability period under applicable	law.	- '	, and the second			
_	F711 A						
7.	This authorization expires upon termin	ation of the litigation.					
	7.0						
8.	I further authorize you to accept either an original or a photostatic copy of this authorization, each having the						
	same full force and effect as if it were it	tself the original.					
_							
9.		10					
	Signature of Patient or Legal Represen	ntative Date					
	Sterrey McD						
	Steven McDermott	11 Relationship to pat					
	Printed name of patient	Relationship to pat	ient or				
	or patient's representative	authority to act for	natient				

IMPORTANT: THIS AUTHORIZATION SHALL BE DEEMED INVALID UNLESS ALL NUMBERED ENTRIES ARE COMPLETED